Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1 OF DALLAS
SUITE 1000
9330 LBJ FREEWAY
DALLAS TX 75243

Respondent Name
INDEMNITY INSURANCE CO

Carrier's Austin Representative
Box Number 15

MFDR Tracking Number
M4-13-1782-01

MFDR Date Received
March 1, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was ordered an Initial Behavioral Medicine Consultation by her treating physician, Stephen Gist, MD. The claim was recommended an allowance of $1,328.10 on 9/20/12 but payment was never received."

Amount in Dispute: $1,328.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 was placed in the insurance carrier representative box number 15 assigned to Downs Stanford PC on March 18, 2013 and stamped received by Downs & Stanford on March 20, 2013 initialed by "FO". A decision will therefore be issued based on the documentation contained in the dispute at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2012	90801 x 5 units and 90889	$1,328.10	$1,238.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 1 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Did the requestor bill in conflict with the NCCI edits?
2. Did the disputed service require preauthorization pursuant to 28 Texas Administrative Code §134.600?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for CPT code 90889 rendered on June 25, 2012. NCCI edits were generated to ensure appropriate reimbursement of the disputed services. The following was identified: "Payment for Procedure Code 90889 is always bundled into payment for other services not specified and no separate payment is made, per Medicare." As a result, reimbursement for CPT code 90889 cannot be recommended.
2. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

   The requestor seeks reimbursement for CPT code 90801 rendered on June 25, 2012.

   The Medicare AMA CPT ® Code book defines CPT code 90801 as "Psychiatric diagnostic interview examination."

   The requestor states in their position summary that the disputed service is an Initial Behavioral Medicine Consultation ordered by the treating physician, Stephen Gist, MD. 28 Texas Administrative Code §134.600(p) (7) requires preauthorization for repeat interviews, the requestor documents that CPT code 90801 is the initial interview. The insurance carrier did not submit documentation to support that this charge was a repeat interview. As a result, the disputed CPT code 90801 will be reviewed pursuant to 28 Texas Administrative Code §134.203.
3. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   The requestor seeks reimbursement in the amount of $1,250.00, the MAR reimbursement for CPT code 90801 per unit is $247.61 x 5 units equals a MAR amount of $1,238.06, this amount is recommended.

   Review of the submitted documentation finds that the requestor is entitled to reimbursement for CPT code 90801 x 5 units in the amount of $1,238.06

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,238.06.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,238.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 9, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).